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BRIEF REPORT

Dual Diagnosis: A Treatment Model for Substance Abuse and Major Mental Illness

Stephen Brady, Ph.D.
C. Michael Hiam, Ph.D.
Ruth Saemann, Psy.D.
Laurie Humbert, Ph.D.
Michael Z. Fleming, Ed.D.
K. Dawkins-Brickhouse, Ph.D.

ABSTRACT: The treatment of "dual diagnosis", co-occurring substance abuse and mental illness, calls for addressing two serious and often confounding problems. The authors introduce an expanded version of the transtheoretical model of change as formulated by J.O. Prochaska and C.C. DiClemente, and suggest that this new version offers a pragmatic approach to the conceptualization and treatment of dual diagnosis. The potential utility of the treatment model is presented through the authors' experiences in working with inner-city, chronic mentally ill individuals with substance abuse problems. Practical guidelines for dual diagnosis group therapy are discussed.

The treatment of substance abusing individuals who have severe and persistent mental illness poses a major challenge to community mental health practitioners. The crisis of dual diagnosis was initially

Dr. Brady is an assistant research professor at the Boston University School of Medicine and the deputy superintendent for research and training at the Dr. Solomon Carter Fuller Mental Health Center. Drs. Hiam, Saemann, Humbert, Fleming and Brickhouse were senior members of the clinical/administrative staff at the Fuller MHC.

Address correspondence to Dr. Brady, Division of Psychiatry at Fuller, Dr. Solomon Carter Fuller Mental Health Center, 85 East Newton Street, Boston, Massachusetts 02118–2389.

recognized in the 1980's, and it is currently estimated that anywhere from 32 to 85 percent of persons with mental illness also have a substance abuse disorder (Minkoff, 1991). Negative consequences of dual diagnosis include client hostility, violence, criminality, suicidality, noncompliance with treatment, homelessness, institutionalization, risk for HIV infection, and neuropsychological dysfunction (Drake, McLaughlin, Pepper & Minkoff 1991; Oepen et al. 1993). For client, family, and clinician, it is a thoroughly demoralizing experience to observe hard-earned therapeutic gains become quickly dissolved by drugs and alcohol.

Treating clients with dual diagnosis is challenging and difficult, the most common result being failure at therapeutic engagement and/or relapse to substance use (Onken & Blaine, 1990). While some clients can be motivated for help and utilize 12 step groups, therapy, medication, and other treatment resources, many clients are treatment resistant. They may minimally comply while hospitalized but go back to substance abuse and avoid all mental health services upon discharge. We have found that these clients often completely deny their substance abuse and mental illness, despite having spent a lifetime of being hospitalized and/or incarcerated for one or both of these problems. Other clients may acknowledge difficulties with substance abuse or mental illness but not both, resulting in client progress made in one area being undermined by continuing problems in the other area.

CONSIDERATIONS IN TREATMENT

Weiss, Miran, and Frances (1992) have argued that there is no "typical" client with dual diagnosis. Reasons for drug and alcohol abuse by persons with mental illness undoubtedly varies by individual. Substance abuse could be primary or secondary to psychiatric symptomatology, or may even in some cases be independent of mental illness. The association between mental disorders and substance abuse is complex and not clearly understood. Therefore, policies that mandate clients be clean and sober before mental health care, or be mentally stable prior to substance abuse help, may be misguided, and have undoubtedly resulted in denying some persons with dual diagnosis of *any* treatment.

Therapeutic approaches towards helping clients with dual diagnosis have remained largely atheoretical, with an emphasis placed upon using existing treatment modalities for substance abuse (i.e., Alcoholics Anonymous) along with traditional interventions for mental illness (i.e., family therapy, neuroleptic medication). This clinical strat-

egy is both pragmatic and appropriate, and the one we use at our mental health center. However, there is also a need for a theoretical structure from which client change in substance abuse *and* mental health problems can be conceptualized. This paradigm would provide, (a) an initial way of assessing client readiness to accept both substance abuse and mental health help, (b) a measure of client progress, (c) a foundation to aid clients in understanding their dual illnesses, and (d) a framework from which to help guide client treatment.

THE TRANSTHEORETICAL MODEL

Prochaska and DiClemente (Prochaska, DiClemente, & Norcross, 1992) have proposed a transtheoretical model of addictions change that shows promise for use with the dually diagnosed client. Prochaska and DiClemente hypothesized five stages of intentional thought and behavior change. Sequentially, these are: *Precontemplation,* when the person may be in denial of his or her problem and is unmotivated for treatment; *Contemplation,* when the individual acknowledges having a problem but is not ready to make concrete behavioral changes; *Preparation,* when planning for change takes place; *Action,* when the person modifies his or her behavior, experiences, or environment to overcome their problems, and; *Maintenance,* in which the person works to prevent relapse and consolidates the changes made during action. A key benefit of the theory from the approach of a community mental health model is its' simplicity which allows for interpretation across differing treatment paradigms (e.g., dynamic, biological, or 12-step models) and levels of staff professionalism (e.g., addictions counselors, social workers, or psychologists).

The transtheoretical model can be used to understand the client as being simultaneously at different stages of change in relation to his or her co-occurring substance abuse and mental health disorders.

This model is further illustrated by the following case vignette.

Maintaining Treatment / Precontemplating Sobriety

Bruce W. is 33 years of age and diagnosed with Schizophrenia and alcohol dependence. He is insightful about his mental illness, actively participates in day treatment, and is knowledgeable about his medications. However, Bruce refuses to even discuss his heavy drinking despite having cirrhosis of the liver and a recent drunken conflict with staff at his group home. He sees no need to attend A.A. Should Bruce be expelled from his residence he will reenter his old cycle of homelessness, decompensation, and hospitalization. Clearly, this clients' success in therapy for his mental illness is threatened by his inability to contemplate personal changes leading to sobriety.

TABLE 1

Examples of Stages of Readiness to Change

	Client Cognitive-Behavioral Change	
Stage	*Substance Abuse*	*Mental Illness*
Pre-contemplation	Denies alcohol problem despite drunk-driving conviction.	Will not acknowledge psychiatric difficulties after suicide attempt.
Contemplation	Occasionally "vows" to self to end crack-cocaine use but continues abuse.	Thinks about calling the neighborhood mental health center but does not.
Preparation	Identifies an NA meeting with intent to attend.	Make appointment with a therapist.
Action	Begins sobriety.	Attends therapy group regularly.
Maintenance	Avoids contact with old drinking friends.	Monitors own emotional state and keeps appointments with psycho-pharmacologist.

THE MODEL IN CLINICAL PRACTICE

Our community mental health center is located in the inner city of a large metropolitan area and serves a predominantly minority (African-American, Latino/a, Asian) client population. Mental illness and substance abuse have been found to be particularly severe among urban minority individuals (Penk, Irvin & Frost, 1992). Many of our clients are dually diagnosed. A recent survey of all day treatment and inpatient consumers found that most (n = 33, 73%) acknowledged having regularly used (≥ 12 months) substances in their past. Based upon interviews and medical charts, 21 (47%) clients were found to be currently (within the past six months) using substances, and most (n = 19, 42%) were judged by *DSM-III-R* (American Psychiatric Association, 1987) criteria to have a moderate (n = 9, 20%), severe (n = 6, 13%), or extremely severe (n = 4, 8%) substance abuse problem. Many clients

reported that their present and past psychiatric crises were precipitated by drug and alcohol abuse.

Confronting the problem of dual diagnosis is a major focus of our treatment at the center. We use a variety of techniques and strategies to help clients progress from one state of change to the next. Because mental illness and substance abuse are intertwined problems, we do not use different techniques and strategies to address each area separately. Both problems need to be treated concurrently with the understanding that they are intrinsically connected.

Initially, stress management techniques are used to decrease clients' subjective distress. These include progressive relaxation, gentle movement exercises, and basic yoga. Our experience has shown us that such non-verbal work is especially helpful for those clients in the precontemplative stages of change. As clients appear ready to accept help for specific problems in their lives, our efforts become largely psychoeducational. We emphasize the links between alcohol, drugs, physical, psychological, and social problems, and give clients interventions they can use to manage symptoms associated with mental illness, including the avoidance of substance use as a way of self-medication. We like a "classroom" approach, utilizing chalk and blackboard when necessary, and always maximize client participation. The aim is to provide an interesting and challenging experience without overwhelming the client with information. The following outline for an early stage dual diagnosis group session is proposed:

a. Client introductions.
b. Defining "dual diagnosis".
c. Listing symptoms of mental disorders.
d. Listing symptoms of substance use.
e. Finding commonality between the two problems.
f. Sharing substance use and mental illness experiences.
g. Review and adjournment.

In later sessions, group confrontation, testimonials, role-playing, and peer-praise are important motivators to help move clients "up" to the next stages of change.

Staff acceptance of the transtheoretical model is critically important for therapeutic effectiveness. Our experience in this regard has been positive, perhaps because the model is simple, clear, and focuses on change and not etiology. Professionals and paraprofessionals, and staff members of differing disciplines are pleased with the model's

descriptive nature which allows for divergent theoretical orientations towards treatment. Importantly, the model lets our staff view client resistance and denial as an expected stage in the change process. This perspective helps us decrease our sense of exasperation, and reduces the possibility that we will communicate a sense of hopelessness and helplessness to one another, and to our clients.

CONCLUSION

Treating clients who have both substance abuse and mental illness is easily one of the most difficult challenges facing the mental health practitioner. It is important to remember that not one, but two problems are always being addressed in these clinical situations, and that the process of change is at times separate, at times the same, but always parallel. Keeping this in mind, clinician, client, and family will have to proceed with change in substance abuse with concurrent treatment of mental illness. Because clients frequently are at different stages of the change process in regards to their two separate but related problems, care should be taken to understand at what stage the client is in for each, and not to assume that client acknowledgement of one problem means acknowledgement of the other.

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